# EC-1

# Hawaii Employer-Union Health Benefits Trust Fund
# ENROLLMENT FORM FOR ACTIVE EMPLOYEES

1. Event:

2. Event Date: (MM/DD/YY)

**See Instructions on reverse side BEFORE completing this form. Refer to your reference guide or our website for plan details.**

| 3a. Employee's Last Name, First, M.I. | | | 3b. Social Security Number: | |
|---|---|---|---|---|
| 3c. Mailing Address: | | | 3g. Marital Status: ☐ Married ☐ Single | 3i. Birth Date: (MM/DD/YY) |
| 3d. City: | 3e. State: | 3f. Zip Code: | 3h. Gender: ☐ Male ☐ Female | 3j. Phone Number – Work |
| 4. Social Security Number of Spouse or Domestic Partner | ☐ State or County - Employee or Retiree ☐ Other – Private, Federal ,etc. | | | 3k. Phone Number – Home |

| 5a. Dependents: First Name, M.I., Last Name (if different) | 5b. Birth Date (MM/DD/YY) | 5c. Social Security Number | 6. Relationship | 7. Gender | 8a. Add | 8b. Delete |
|---|---|---|---|---|---|---|
| | | | | M☐F☐ | ☐ | ☐ |
| | | | | M☐F☐ | ☐ | ☐ |
| | | | | M☐F☐ | ☐ | ☐ |
| | | | | M☐F☐ | ☐ | ☐ |
| | | | | M☐F☐ | ☐ | ☐ |

9. Plan Selections, Changes or Cancellations - Make your selection by checking the box(es) for the appropriate benefit plans below. Select either Self, Family or Cancel/Waive coverage. Choose only one box in each plan section.

| ***Plan Section*** | ***Carrier Selection*** | ***Self*** | ***Family*** | ***Cancel / Waive*** |
|---|---|---|---|---|
| Medical/Drug, Chiropractic (choose Self, Family or Cancel/Waive) | HMSA PPO Medical and Drug, MBAH ChiroPlan | ☐ | ☐ | ☐ |
| | Kaiser Medical and Drug, MBAH ChiroPlan | ☐ | ☐ | |
| | HMSA Dual Coverage Medical/Drug, Chiropractic available from April 1, 2004 effective date (I have medical/drug coverage from another source outside of EUTF) | ☐ | ☐ | |
| | Royal State Dual Coverage Medical/Drug, Chiropractic: available from February 1, 2004 effective date (I have medical/drug coverage from another source outside of EUTF) | ☐ | ☐ | |
| Dental (choose Self, Family or Cancel/Waive) | HDS Dental | ☐ | ☐ | ☐ |
| | HDS Dual Coverage Dental (I have dental coverage from another source outside of EUTF) | ☐ | ☐ | |
| Vision (choose Self, Family or Cancel/Waive) | VSP Vision | ☐ | ☐ | ☐ |
| | VSP Dual Coverage Vision (I have vision coverage from another source outside of EUTF) | ☐ | ☐ | |
| AETNA Life Insurance Plan | | ☐ | | ☐ |

10. **State Employees ONLY (Premium Conversion Plan)** ☐ Enroll ☐ Do NOT Enroll ☐ Change amount ☐ Cancel PCP

11. Comments:

12. Certification (see instructions on back of this form)

**Employee Signature:** _____ **Date:** _____

13. DPO Signature: _____ Received Date: _____ DPO Phone: _____ DPO FAX: _____

| 14. Dept. ID# | 15a. Dept: | 15b. Division/ School: | 16. Barg. Unit: |
|---|---|---|---|
| | | | |

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DPO's: Fax to 586-2161 **OR** send via messenger to EUTF at 201 Merchant St., Suite 1520, Honolulu, HI 96813 **OR** mail to EUTF, P.O. Box 2121, Honolulu, HI 96805-2121

# INSTRUCTIONS FOR COMPLETING EC1 FORM

A. Print or type clearly, if form is unreadable it may be sent back to you.

B. **Please submit form to your Personnel Office or Department Personnel Officer (DPO) for verification.**

C. Sections:

1. Event – Please describe the event. For example, Birth, Marriage, Divorce, Loss Coverage, Termination, Transfer In, Transfer Out, Address Chg, Marital Status Chg, Retire, Rehire, New Hire, Death, Student, Add Dep, Cancel etc. If there are simultaneous events, please describe the most prevalent event. For example, if the event is a birth and address change, enter Birth in the event section.
2. Event Date – Please enter the date the event took place.
3. Enter Employee's information for: Last Name, First Name, M.I., Social Security No., Mailing Address, City, State, Zip Code, Marital Status, Gender, Birth Date and Daytime/Evening Phone Number in the appropriate spaces.
4. Enter Social Security Number of Spouse or Domestic Partner and check appropriate box.
5. Enter Employee's Dependent(s) Name, Birth date, and SSN.
   If listing more than 5 dependents, write "Continued" on the last line of the Dependent section. Use a separate of paper to list additional dependent(s) information.
6. Use the following codes for Relationship column:
   **SP** = Spouse **CH** = Child **DC** = Disabled Child$^{\surd\surd}$
   **DP** = Domestic Partner$^{\surd}$ **DPC** = Domestic Partner Child$^{\surd}$
   **For Relationship codes with $^{\surd}$ and $^{\surd\surd}$, please see item #17 below for other required forms.**
7. Gender – circle either M or F.
8. Check add box to add dependent, check delete box to delete dependent.
9. Plan Selections (See Reference Guide for Plan Coverage Details). For Dual Medical plan coverage details see your personnel office or visit the EUTF website. Select only 1 box from each Plan Section.
   If you are selecting Medical Dual, Vision Dual or Dental Dual, you must have other coverage from another source outside of EUTF.
10. PCP – this section is for State employees only. Select Enroll, Do Not Enroll, Change amount, or Cancel. PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pre-tax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. State employees, who are changing PCP deduction amounts, please inquire with your DPO or DHRD on completing a PCP election change (PCP-2) form. (See page 11 of the Reference Guide for Active Employees).
11. Comments – use this section for your comments
12. **Certification**
    Signature of Employee certifies that the information provided in this application is true and complete. Employee agrees to abide by the terms and conditions of the benefit plans selected. Employee authorizes their employer or finance officer to set the effective dates of coverage and to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.
    Employee affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student. Employee affirms that they have non-EUTF plan benefits for each Dual Coverage Plan selected. Employee signature also affirms that they have read and understood the PCP section in the Reference Guide for Active Employees.
    Please enter date of Employee's signature.
13. DPO signature certifies applicant is eligible as defined in Chapter 87A, HRS. Enter date you received EC1 from your employee. EUTF rules state that enrollment change forms must be received within 30 days of the event. DPO – Please provide your phone and fax numbers.
14. Department ID code – DPO, please enter your appropriate Department ID code. For example, 010021 for Department of Education, 040028 for City and County of Honolulu Emergency Services, etc.
15. Dept: and Division/School: - Optional fields for DPO use only.
16. Bargaining Unit number – DPO, please enter the appropriate bargaining unit for this employee.
17. Other EUTF forms to include with EC1 (if applicable):
    $^{\surd}$Domestic Partnership Declaration or Termination
    $^{\surd}$Domestic Partner PCP Acknowledgement Form (State Employees with PCP enrolling Domestic Partners)
    $^{\surd}$Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
    $^{\surd\surd}$D-1 (5/2003) for enrolling disabled child
    Life Insurance Waiver Form (If waiving life insurance)
    AETNA Life Insurance Designation of Beneficiary (If enrolling for the first time or changing beneficiaries)